

Care Quality Commission

Inspection Evidence Table

JS Medical Practice (1-552881693)

Inspection date: 13 December 2018

Date of data download: 07 December 2018

Overall rating: add overall rating here

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/18.

Effective

Rating: Good

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
Appropriate referral pathways were in place to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) (NHSBSA)	0.61	0.49	0.81	No statistical variation

Older people

Population group rating: Good

Findings

- Older patients who were frail or might be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- The practice worked proactively with local pharmacies to carry out medication reviews, and arranged to prescribe medicines in blister packs where patients would benefit. Blister packs display all medicines that a patient is due to take and the days and times when they are due to be taken.

People with long-term conditions Population group rating: Good

Findings

The practice was aware that its performance for management of this patient group was lower than average in some areas.

- At our last inspection in June 2018 we reviewed the then latest published (2016-17) QOF data, these showed the practice's performance, for example: the percentage of diabetic patients who had a last blood sugar measurement in the acceptable range was 64%, which was below the CCG average of 77% and the national average of 80% (QOF data for 2016-17).
- At this inspection the QOF performance data for 2017-18 had been published showing a small improvement in its performance in this area to 65% of diabetic patients with a blood sugar measurement in the acceptable range. However, this was still below the local and national averages (76% and 79%, respectively).
- The practice had taken considerable action to improve its performance and showed us its year to date performance data for QOF year 2018-19. The unpublished, unverified, data showed that by mid-December 2018 it had achieved 71% of diabetic patients had a blood sugar measurement in the acceptable range, with over three months left in its programme.
- We saw evidence that the improved performance, from the practices' unpublished and unverified QOF data for 2018-19, was consistent across all diabetes indicators.
- The practice had started offering monthly diabetes specialist nurse (DSN) clinics. These alternated between the three practice locations. A care navigator also attended the clinics to educate patients about the three treatment targets of: blood pressure; cholesterol; and blood sugar levels. From January 2019 DSN clinics were scheduled to run each week.
- One of the GP partners had worked jointly with the DSN to update his prescribing knowledge for that patient group.
- At our last inspection the percentage of patients with hypertension who had a last blood pressure reading within the acceptable range was 66% which was below the local and national averages (80% and 83%, respectively) (QOF data for 2016-17).
 - At this inspection the QOF performance data for 2017-18 had been published showing an improvement in its performance in this area to 70% of eligible patients who had a last blood pressure reading within the acceptable range. However, this was still below the local and national averages (80% and 83%, respectively).
 - The practice had taken action to improve its performance and showed us its year to date performance data for QOF year 2018-19. The unpublished, unverified, data showed that by mid-December 2018 it had achieved 77% of eligible patients who had a last blood pressure reading within the acceptable range, with over three months to continue with its programme.
- Since July 2018 the practice had run additional advanced nurse practitioner chronic disease management clinics for patients with long-term conditions including COPD, asthma, diabetes, atrial fibrillation and high blood pressure.
- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GPs worked with other health and care professionals to deliver a coordinated package of care.

- The health care assistant had received training to undertake diabetic foot checks and to develop hypertension care plans with support from the GPs and advanced nurse practitioner.
- The practice had introduced dedicated clinical sessions to provide home visits to housebound patients. These included chronic disease reviews, undertaken by the GP and advanced nurse practitioner, completion of mutually agreed care plans, and consideration of carers needs.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- The practice had appointed and trained a member of the reception staff to lead on patient call and recall. The practice was using a combination of written, phone and text messages to invite patients to attend for appointments.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- The practice consistently exception reported a lower percentage of patients than the local and national averages.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	65.3%	76.3%	78.8%	Variation (negative)
Exception rate (number of exceptions).	5.5% (37)	14.4%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF)	61.6%	77.0%	77.7%	Variation (negative)
Exception rate (number of exceptions).	6.5% (44)	11.5%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF)	67.3%	75.8%	80.1%	Variation (negative)
Exception rate (number of exceptions).	5.6% (38)	11.3%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)	69.7%	76.9%	76.0%	No statistical variation
Exception rate (number of exceptions).	2.7% (14)	5.0%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	93.5%	91.0%	89.7%	No statistical variation
Exception rate (number of exceptions).	6.1% (6)	10.5%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	70.1%	80.3%	82.6%	Significant Variation (negative)
Exception rate (number of exceptions).	2.9% (37)	6.5%	4.2%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) (QOF)	91.5%	85.2%	90.0%	No statistical variation
Exception rate (number of exceptions).	6.3% (4)	11.2%	6.7%	N/A

Families, children and young people

Population group rating: Good

Findings
<p>The practice was aware that its performance for childhood immunisations was below the minimum 90% target.</p> <ul style="list-style-type: none"> At our last inspection in June 2018 we reviewed the then latest published (2016-17) NHS England data, these showed the practice's performance, for example: <ul style="list-style-type: none"> 88% of children aged two had received their booster immunisation for pneumococcal infection, which was below the minimum 90% target; 68% of children aged two had received immunisation for measles, mumps and rubella (MMR) (2016-17 NHS England data), which was significantly below the minimum 90% target. At this inspection the NHS England performance data for 2017-18 had been published showing that: <ul style="list-style-type: none"> There had been a decline in performance, with 87% of eligible children aged two receiving their booster immunisation for pneumococcal infection, this was still below the minimum 90% performance target; There had been an improvement, with 87% of eligible children aged two receiving immunisations for measles, mumps and rubella (MMR) (2017-18 NHS England data). This was still below the minimum 90% performance target. The practice had taken considerable action to improve its performance and showed us its year to date performance data for the year 2018-19. The unpublished and unverified data showed that by mid-December 2018: <ul style="list-style-type: none"> 94% of eligible children aged two had received their booster immunisation for pneumococcal infection, which was above the 90% minimum target;

- 83% of eligible children aged two had received immunisations for measles, mumps and rubella (MMR). Although this was below the 90% minimum performance target, the practice had over three months remaining in its immunisations programme.
- Childhood immunisations were carried out in line with the national childhood vaccination programme.
- A member of the administration team had been given the responsibility of overseeing immunisation performance.
- There was a high annual turnover of patients, 20% of patients moved away from the practice each year, which made it difficult to ensure that children were brought in for their immunisations. In addition, a number of patients refused immunisations on behalf of their children.
- The practice had developed a template for parents to sign if they refused to allow their children to be immunised, and these were then stored on the patient's record.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice told us there had been inconsistencies in recording information for QOF purposes between the three practice locations, which it had worked to improve. It had implemented a tracking system, led by the advanced nurse practitioner, to record its performance. It reported on various practice targets both clinical and non-clinical, including QOF chronic disease areas, cytology and child immunisations. It reported weekly and monthly progress against practice targets for each of the three practice locations. This had encouraged staff at each practice location to achieve the best performance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.
- Young people could access services for sexual health and contraception.
- The practice consistently exception reported a lower percentage of patients than the local and national averages.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018)(NHS England)	132	149	88.6%	Below 90% minimum (variation negative)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England)	172	197	87.3%	Below 90% minimum (variation negative)
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2017 to 31/03/ 2018) (NHS England)	177	197	89.8%	Below 90% minimum (variation negative)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	171	197	86.8%	Below 90% minimum (variation negative)

Working age people (including those recently retired and students)

Population group rating: Good

Findings
<p>The practice was aware that its performance for management of this patient group was lower than average in some areas.</p> <ul style="list-style-type: none"> At our last inspection in June 2018 we reviewed the then latest published (2016-17) data, these showed the practice's performance, for example: the percentage of eligible patients who had been screened for cervical cancer was 63% which was below the 80% coverage target for the national screening programme. (Public Health England data for 2016-17). The practice had taken considerable action to improve its performance and showed us its year to date performance data for year 2018-19. We saw the unpublished, unverified, performance data which showed that by mid-December 2018 it had achieved 77% of eligible patients who had been screened, with over three months remaining in its programme. It offered appointments throughout the week, female sample takers were available and clinicians opportunistically invited patients for screening. The practice was participating in a new scheme commissioned by NHS England and Public Health England to text a reminder message to patients who were due to receive a smear test. A member of the administration team had been given the responsibility of contacting eligible

patients to invite them for screening as well as following up any missed appointments.

- At our last inspection the practice's uptake for breast and bowel cancer screening was below the national average. For example,
 - 56% of women aged 50-70 had been screened for breast cancer in the last 36 months, compared to a CCG average of 62% and a national average of 70%; and,
 - 40% of people aged 60-69 had been screened for bowel cancer in the last 30 months, compared to a CCG average of 46% and a national average of 55%.
- At this inspection we saw the practice's latest unpublished and unverified performance data which showed that:
 - 62% of women aged 50-70 had been screened for breast cancer in the last 36 months had been screened for breast cancer; and,
 - 42% of eligible patients had been screened for bowel cancer in the last 30 months.
- There were alerts on the system when patients became eligible for screening, enabling clinicians to opportunistically invite patients to participate.
- There was an alert on the system that highlighted eligible patients who had not attended for breast or bowel cancer screening, and where patients had not returned the bowel cancer screening kits. The practice used these alerts to actively follow-up these patients.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- The practice told us there had been inconsistencies in recording information for QOF purposes between the three practice locations, which it had worked to improve. It had implemented a tracking system, led by the advanced nurse practitioner, to record its performance. It reported on various practice targets both clinical and non-clinical, including QOF chronic disease areas, cytology and child immunisations. It reported weekly and monthly progress against practice targets for each of the three practice locations. This had encouraged staff at each practice location to achieve the best performance.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks.
- The practice consistently exception reported a lower percentage of patients than the local and national averages.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2016 to 31/03/2017) (Public Health England)	62.5%	67.4%	72.1%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (PHE)	55.5%	62.3%	70.3%	N/A

Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(PHE)	40.4%	46.2%	54.6%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (PHE)	58.6%	76.9%	71.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2016 to 31/03/2017) (PHE)	38.7%	43.8%	51.6%	No statistical variation

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice offered priority appointment access to patients with disabilities.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- At our last inspection the then latest published (2016-17) QOF figures showed that the practice's performance for management of patients was below average in some areas. For example:
 - 74% of patients diagnosed with dementia had their care plan reviewed in a face to face meeting in the previous 12 months. This was lower than the local average of 85% and the national average of 84%.
 - 68% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a recorded alcohol consumption figure on their medical records. This was significantly lower than the CCG average of 90% and the national average of 91%.
- At this inspection the QOF performance data for 2017-18 had been published, this showed, for example:
 - 76% of patients diagnosed with dementia had their care plan reviewed in a face to face meeting in the previous 12 months. This was lower than the local average of 84% and the national average of 83%.
 - 92% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a recorded alcohol consumption figure on their medical records. This was significantly lower than the CCG average of 90% and the national average of 90%.
- The practice showed us its unpublished unverified QOT year to date performance data for the year

2018-19, this showed the practice's performance, with over three months left in its programme to continue to record information about this patient group. We saw that, for example:

- 86% of patients diagnosed with dementia had their care plan reviewed in a face to face meeting.
 - 84% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a recorded alcohol consumption figure on their medical records.
- The practice was aware of its level of performance. It told us there had been inconsistencies in recording information for QOF purposes between the three practice sites. It had addressed this in clinical meetings, and alerts had been developed on the computer system to prompt clinicians to opportunistically complete any work that was outstanding.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- A GP partner had taken the lead role for mental health and dementia patient reviews, providing extra dedicated appointments with longer appointment times for complex patients.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice offered annual health checks to patients with a learning disability.
- The practice consistently exception reported a lower percentage of patients than the local and national averages.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in their record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	74.1%	90.2%	89.5%	Variation (negative)
Exception rate (number of exceptions).	3.6% (6)	6.9%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	91.5%	90.1%	90.0%	No statistical variation
Exception rate (number of exceptions).	1.8% (3)	6.8%	10.5%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	75.7%	84.4%	83.0%	No statistical variation
Exception rate (number of exceptions).	7.5% (3)	6.3%	6.6%	N/A

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	508.5	-	537.5
Overall QOF exception reporting (all domains)	3.6%	5.6%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Y

Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years

Theophylline monitoring of levels audit. Theophylline is a	Findings: <ul style="list-style-type: none"> The audit revealed that theophylline monitoring was not
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<p>medicine used in therapy for respiratory diseases such as chronic obstructive pulmonary disease (COPD) and asthma.</p>	<p>systematic and it could be overlooked as other conditions or monitoring took precedence.</p> <ul style="list-style-type: none"> • Dosage can be potentially go over therapeutic levels and it can interact with other medications. Monitoring is therefore important. • Thirteen patients who had not had their theophylline levels checked were contacted and invited for blood tests. • A 'pop up' alert on the computer system had been added to alert clinicians seeing patients taking this medicine that patients require blood tests. • Theophylline had been added to drug monitoring searches so that the practice could readily identify patients who needed blood tests. • Learning was shared with the clinical team via email and in a clinical meeting.
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Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff. This included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Y

Coordinating care and treatment

Staff worked together and with other organisations to deliver effective care and treatment.

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	92.1%	94.8%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.4% (9)	0.8%	0.8%	N/A

Consent to care and treatment

The practice always obtained / was unable to demonstrate that it always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y

Well-led

Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme in place, including a succession plan.	Y

Vision and strategy

The practice had a clear vision and credible strategy to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy in place to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y

Culture

The practice had a culture which drove high quality sustainable care / The practice culture did not effectively support high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y

Examples of feedback from staff or other evidence about working at the practice

Source	Feedback
Staff Interviews	<p>Staff we spoke to told us they felt they were a good team that worked well together and they felt supported by the management. They said the GPs and practice manager were approachable and helpful.</p> <p>Staff told us they felt the practice was open in its approach and friendly.</p>
Partner interview	<p>The practice had recently commenced working with the local GP Federation, Federated4Health, to provide management support across the three practice locations. The practice had purchased a package of support known as 'Practice Manager Assist', to facilitate further developments and improvements.</p> <p>The practice held an away day on 6 December 2018, attended by staff from all three locations, to introduce the new management structure, strengthen team work, foster good communication between the locations and help to share the common goal to achieve well and provide high quality primary care services for its patients.</p> <p>The staff had engaged well with the process and had commented on how beneficial they had found the experience.</p>

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

	Y/N/Partial
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There were governance structures and systems in place which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems in place which were regularly reviewed and improved.	Y
There were processes in place to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y

Any additional evidence or comments

- During our last inspection we found that there was no standard procedure for recording QOF (Quality and Outcomes Framework) and screening programme information across the practice's three branches. This had resulted in its QOF achievement being, in some areas, significantly below CCG and national averages. Its performance for screening of eligible patients for breast and bowel cancer was below CCG and national averages. In addition, its performance for uptake of childhood immunisations was below the minimum World Health Organisation targets.
- At this inspection the practice told us about changes it had implemented to standardise procedures across all three locations to improve its performance in these areas. We found that the practice had worked to improve its QOF, childhood immunisations and cancer screening performance. For example, it had implemented a tracking system, led by the advanced nurse practitioner, to record performance across the three locations. This reported on various practice targets, both clinical and non-clinical, including QOF chronic disease areas, cytology and child immunisations performance. It enabled the practice to monitor weekly and monthly progress against its targets for each of the three practice locations. It had encouraged staff at each practice location to achieve the best performance.
- The practice had also: improved access for these patient groups with additional clinical time; undertaken more dedicated home visits for housebound patients; put alerts on the computer system to prompt clinicians to use all opportunities to complete any work that was outstanding; trained the HCA to undertake a greater range of work; and empowered non-clinical staff by training them and giving them greater responsibilities, such as appointing a lead for patient calls and recalls.

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

	Variation Band	Z-score threshold
1	Significant variation (positive)	$Z \leq -3$
2	Variation (positive)	$-3 < Z \leq -2$
3	No statistical variation	$-2 < Z < 2$
4	Variation (negative)	$2 \leq Z < 3$
5	Significant variation (negative)	$Z \geq 3$
6	No data	Null

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:

<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Glossary of terms used in the data.

- **COPD**: Chronic Obstructive Pulmonary Disease
- **PHE**: Public Health England
- **QOF**: Quality and Outcomes Framework
- **STAR-PU**: Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.